

BlueHub Assessment Summary and Treatment Plan

This form aims to:

- assist your psychological formulation and treatment planning
- help the worker to determine their goals
- improve treatment by providing information to other clinicians involved in the worker's care
- inform the agent and other clinicians about the worker's treatments needs and progress
- ensure treatment is appropriate and aligns with the Clinical Framework for the delivery of health services.

Details

Worker's name:

Claim Number:

Occupation/Job title:

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General Practitioner's name:

Referrer's name:

Date of referral:

Date of first session:

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1. Your DSM diagnosis (or provisional diagnosis) with respect to the claimable injury, using the published version of the DSM:

2. With respect to the claimable injury, describe the psychological and physical symptoms the worker is currently presenting:

3. **Describe the impact of these symptoms on the following areas:**

3.1 Home life
3.2 Social engagement
3.3 Emotional wellbeing/quality of life
3.4 Readiness to return to work or progress with the support of occupational rehabilitation services
3.5 Other

4. Details of any other psychological or physical conditions	Considerations for treatment and additional support

5. Details of any factors that could enhance recovery (personal strengths or situational factors)

6. Details of any factors that may impede recovery	Considerations for treatment and additional support

7. Goals and treatment

7.1 Home life	Treatment modality/interventions/strategies
7.2 Social engagement	Treatment modality/interventions/strategies
7.3 Emotional wellbeing/quality of life	Treatment modality/interventions/strategies
7.4 Developing work/training capacity	Treatment modality/interventions/strategies
7.5 Other	Treatment modality/interventions/strategies

8. Outcome measures – including individual goal attainment scales and validated psychometrics, results and interpretation

Scale	Date	Result	Interpretation

9. Anticipated treatment frequency and delivery mode

9.1 How many sessions do you anticipate are needed within the next 3-6 months?

9.2 What frequency?

9.3 Face-to-face or telehealth?

9.4 Provide a clinical rationale for the treatment frequency and modality

10. What else would help the worker with their recovery at this time?

11. Which other clinicians have you, or will you, collaborate with to enhance the worker's treatment and recovery?

Professional discipline(s)

Name(s)

12. Clinician Details

Name

Address

Provider Number

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Clinician's signature

Date

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13. Consent (provider can sign on behalf of worker if verbal consent has been provided)

Signature of worker, parent, or guardian

Date

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Full name (please print)

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What's next?

A case manager will contact you if they require any further information.

Please contact the worker's case manager if there is anything you would like to discuss or recommendations to follow up.

For Psychologists, use the **BH100** service funding code for submission of the form.

For Mental Health Social Workers, use the **BH400** service funding code for submission of the form.